Yael Schweitzer, LCSW, BC-DMT
Mindfulness-Based Therapy

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THERAPY POLICIES &
INFORMED CONSENT STATEMENT

Please read this information carefully and let me know if you have any questions or concerns.

PROFESSIONAL CREDENTIALS: I have a Master of Social Work Degree and I am a Licensed Clinical Social Worker in the State of Oregon.

OFFICE HOURS: All office visits are by appointment only and are scheduled by me. Sessions are 45 or 60 minutes in length. Voice Mail is available to take messages. If your call is an emergency, please call the Multnomah county health crisis line at: 503-988-4888, or go to the nearest hospital emergency room or dial 911.

CANCELLATIONS: When you make an appointment, please try to keep it. If you are unable to keep your scheduled appointment, please call and leave a message stating the reason you are canceling. Cancellations need to be made at least 24 hours in advance or you will be charged for the reserved appointment time. Your health insurance will not pay for appointments you fail to keep. You will be personally responsible to pay out of pocket for the full session fee.

CONFIDENTIALITY: Discussions occurring in psychotherapy are confidential or privileged communication. It is important to note that it is the client who holds the privilege. I cannot discuss your case with anyone else without your written permission.

Legal exceptions to confidentiality include:

(1) when a client is a danger to themselves or others;
(2) when there is reason to believe that a minor or elderly person was a victim of a crime, neglect, or sexual / physical abuse;
(3) when ordered by a judge to release information;
(4) when necessary to pursue non-payment of your bill for services rendered;
(5) when a client initiates legal action or makes a complaint against the therapist.

When the client is a minor child, other conditions such as divorce proceedings, lawsuits or other legal matters between the parents may affect confidentiality.

CLIENT'S RIGHTS & RESPONSIBILITIES: Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods of therapy, which may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as the work progresses. Remember, you always retain the right to request changes in treatment, to end treatment at any time, or to request a referral to another therapist.

HEALTH INSURANCE: If you are using a health insurance benefit to pay for these services, you need to be aware of what this may mean. Most insurance companies require specific clinical information about you in order to authorize and/or pay for treatment. Health insurance companies usually limit mental health coverage to:

- Services that are considered "medically necessary". This typically means that there is evidence of a diagnosable condition with acute symptoms.
- Conditions that are treatable by short-term, problem-focused, or goal-oriented approaches whenever possible.

This means your insurance company may only cover a limited number of sessions to address a specific diagnosis or problem. Furthermore, a utilization review/quality assurance group set by the insurance company or a peer consultation group may review your case or file. In such a situation, your name and identifying information will be kept confidential. Health insurance may or may not cover all services provided. For example, insurance companies rarely reimburse for phone calls.

FEE AGREEMENT: I agree to pay the following fees:

Service		Fee
Initial Session *(diagnostic interview)*	60 minutes	$200
Individual Psychotherapy	45 minutes	$165 per session
Individual Psychotherapy	60 minutes	$185 per session
Couples/Family therapy	60 minutes	$185 per session
Group Therapy		$50 per session
Extended phone conversations		$185 per hour
Reports/review of records		*(prorated)* $150 per hour

I understand that payment of my fee or co-payment is due and payable at the time of each counseling session, unless otherwise arranged.

I agree to pay the full fee as stated above for missed appointments or appointments canceled with less than 24 hour notice.

Payment Plan: [To be completed with your therapist]

[ ] Payment of full fee at time of each appointment.

[ ] Client's co-payment of $ _____ due at time of each appointment.

[ ] Other: _____

_____

RELEASE OF INFORMATION:

I authorize the release of my/our clinical record information to my/our insurance company for the purpose of billing, authorization of treatment, healthcare credentialing, utilization review and quality assurance review.

_____ _____

(Signature)
I authorize release of any information necessary to process my insurance claim.

(Signature)
I authorize payment of medical benefits directly to the providers of services.

I have read and understood the agreement, and agree to assume responsibility for the fees incurred in the provision of professional services.

CLIENT OR GUARDIAN:

1) _____ _____
Date

2) _____

3) _____ _____
Therapist